# The impact of prior recourse to traditional medicine on the out-of-pocket expenditure of HIV/AIDS patients in Niger

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The Leverhulme Trust
Research funded by the Leverhulme Trust, UK

## Aims

- To quantify the financial impact of prior recourse to traditional health practice (THP) on patients with HIV/AIDS, in terms of money spent on traditional healers, deteriorating health and higher costs upon entry into the national treatment program.
- To identify socio-economic groups within the sample having a preference for traditional medicine.

## Methodology

- In the absence of adequate formal statistical records, semi-structured interviews were carried out in 4 health facilities providing ART treatment in Niger, from September 2007 to February 2008, using a patient-translator.
- Two populations were identified:
  **[THP]: Patients on ART who entered the formal health system after consulting THP**
  **[No THP]: Patients on ART, never having consulted THP**
- Cost data were broken down to detail expenditures; regression analysis was performed to evaluate the impact of THP on subsequent patient expenditure and to investigate socio-economic factors indicating a preference for THP before entering the formal health system.

## Results

### The burden of traditional medicine

The majority of patients who consulted traditional healers before the formal system chose not to continue seeing traditional doctors after entry into the formal system

| | Total sample |
|---|---|
| THP before HIV test | 43.24% |
| Continued THP after HIV test | 2.70% |
| New THP after test | 0.54% |

| | THP | No THP |
|---|---|---|
| % hospitalised | 48.8 | 26.7% |
| Mean days hospitalised | 24.6 | 8.35 |
| Mean daily cost of hospitalisation | US$ 9.48 | US$ 10.17 |
| Mean monthly cost of medical care after test | US$ 10.25 | US$ 8.06 |
| % sample who sold fixed assets | 75% | 39% |
| % sample reduced household expenditure | 71.3% | 66.7% |

Controlled for income, education and gender, patients who previously consulted THP were (statistically significantly):

- more likely to be hospitalized (longer and at greater overall cost to the pts)
- not likely to pay more for medical treatment after hospitalization more likely to have sold fixed assets (as opposed to liquid assets) while all patients reduced household expenditure as a result of treatment costs

### Determinants of preference for traditional medicine

Of the social characteristics surveyed, none were statistically significant in determining a preference for traditional medicine, include the time taken to travel to treatment centre. Descriptive statistics suggest that traditional medicine is more popular among those with insecure status within society, notably the poor and uneducated.

| | | THP | No THP |
|---|---|---|---|
| Mean age (years) | | 34.3 | 35.3 |
| Mean travel time (hours) | | 1.47 | 1.75 |
| Marital Status | Married | 45% | 55% |
| | Single | 37% | 63% |
| | Widowed | 28% | 72% |
| | Divorced | 66% | 33% |
| Highest level of education attained | None | 52% | 48% |
| | Madrassa | 56% | 44% |
| | Primary | 33% | 68% |
| | Secondary | 37% | 63% |
| | Higher | 17% | 83% |

| | | THP | No THP |
|---|---|---|---|
| Gender | Male | 45% | 55% |
| | Female | 43% | 58% |
| House material | Straw | 53% | 47% |
| | Mud brick | 53% | 47% |
| | Mixed | 13% | 87% |
| | Concrete | 29% | 71% |
| Income groups | None stated | 42% | 58% |
| | Income = 0 | 38% | 63% |
| | 1 st Quartile | 62% | 38% |
| | 2 nd Quartile | 57% | 43% |
| | 3 rd Quartile | 35% | 65% |
| | 4 th Quartile | 35% | 65% |

## Discussion

Traditional health practitioners (THP) remain the **health provider of first resort** for the majority of patients interviewed, yet may **hinder access to effective treatment,** resulting in **increased financial burden to the patient, especially at entry into the formal health system.** This could be because:

- The THP is paid per act rather than by result, so the THP has an economic incentive to encourage repeat interaction and to discourage referral
- The THP may not know about, or believe in, the effectiveness of ART

As well as the cost to the patient documented in this study, traditional medicine is likely to cost more to the state health budget through higher rates of hospitalisation.

Traditional medicine has no effective remedy for HIV/AIDS; consequently, patients make payments `in ignorance' and arrive for treatment in a weakened medical and financial state. Once within the healthcare system, there is an initial opportunity cost of consulting THP (i.e. prolonged hospitalisation), but care thereafter is unaffected by prior recourse to THP.

## Conclusion

The indistinct social characteristics of patients seeking traditional remedies, from an urban sample, suggest that recourse to THP is culturally and socially ingrained within the population of Niger. While access to the Nigerien health system remains limited by geographical, cultural and financial barriers, a second-best solution may be to harness the coverage and cultural integration of traditional healers.

Targeting specific patient populations would not be as cost-effective as bringing THP within the sphere of influence of the formal health sector. There is therefore a strong rationale for targeting traditional health providers for awareness campaigns, strengthening the referral process between the traditional and formal health sectors.

There is considerable danger associated with enhancing the status of potentially dangerous traditional practices which must be considered by policy makers designing interventions.



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ICASA 2008
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